

**STUDENT REGISTRATION FORM**

**Alexandria Township School District**  
Lester D. Wilson Elementary School  
525 County Road 513  
Pittstown, NJ 08867  
908-996-6812

**Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_ **Date Requested:** \_\_\_\_\_

**Release of Confidential Student Records**

As parent/guardian of the student named above, I hereby authorize the release of confidential information to Alexandria Middle School from:

School \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Records to be included are:

- |   |   |
|---|---|
| <input type="checkbox"/> Transcripts              | <input type="checkbox"/> Health Records |
| <input type="checkbox"/> Standardized Test Scores | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Behavior Records         |   |

**Please mail all confidential information within 10 days of request to:**

**Lester D. Wilson Elementary School**  
**525 County Road 513**  
**Pittstown, NJ 08867**  
**ATTN: Student Records**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

Date Received: \_\_\_\_\_

Phone No.: \_\_\_\_\_